

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048415

STATE FILE NUMBER

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 241

DO NOT WRITE
ON THIS STUB

AMENDED

FILED DEC 26 1963

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Webb City	
Length of stay in 1b 20 Mos.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Maryetta Rest Home		d. STREET ADDRESS (If outside, give location) 409 N. Oronogo St.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Arthur Ferguson		4. DATE OF DEATH Month Day Year December 17, 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1881
9. AGE (last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee		10b. KIND OF BUSINESS OR INDUSTRY Burlington R.R.	
11. BIRTHPLACE (City and state or country) Greenfield, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Reubon A. Ferguson		13b. MOTHER'S MAIDEN NAME Eliza Ann Poindexter	
14. NAME OF HUSBAND OR WIFE Mrs. Anna Palone, Webb City, Mo.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Mrs. Anna Palone, Webb City, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis - generalized</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 12/14/63 to 12/17/63 and last saw him alive on 12/16/63 Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F. Wendell Ponce, M.D.		22b. ADDRESS 612 Main Carthage Mo.	22c. DATE SIGNED 12/17/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/19/1963	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	23d. LOCATION (City, town, or country) (State) Neosho, Missouri
24. FUNERAL DIRECTOR Hedge-Lewis Funeral Home Webb City, Mo.		25. DATE RECD. BY LOCAL REG. 12-18-63	26. REGISTRAR'S SIGNATURE [Signature]

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59
10497
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4561

P. O. Address Wible City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.